Miss Faith Jennifer Kaye

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Inspection report

Faiths Care
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 29 and 30 November 2016, and on the 5 December 2016. The first day was unannounced the other days were announced. This service is a domiciliary care service with less than 30 people using the service. The service provided personal care and support services for a range of people living in their own homes. These included older people, people living with dementia and people with a physical disability. We carried out this inspection because we received some information of concern.

The last time we inspected this service was on the 19 February 2016, we also carried out this inspection because concerns had been raised with us, but found that the concerns raised had been dealt with and the service was found to be offering a Good service to the people they supported.

The service had a manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was also the provider of this small service.

Overall people were positive about the staff that supported them, but felt that the management team were disorganised. People told us they did not always feel safe, that staff were kind and the care they received was normally good, but the staff were very often late, did not always stay the for the full booked time and sometimes their visits were cancelled at short notice.

There was not enough staff to ensure that people were properly cared for and the manager did not always using safe recruitment practices when recruiting new staff.

Care plans were not always in place or had been updated when people's needs had changed, so that staff supporting people did not know what their needs were or if there was any risks to that person's health and wellbeing.

We could not be sure that people received their medicines safely, in some of the care plans we saw that people's medication was not recorded properly and the medication administration records were not always completed properly. People were supported to maintain good health and had assistance to access to health care services when needed.

People were supported at mealtimes to access food and drink of their choice where needed, but because of poor time keeping people were sometimes being offered their meals at inappropriate times. This was because with staff arriving late for some visits and, on occasion, early for others people would be given their meals too close together.

The service was not always well led. Because of staff vacancies the normally office based manager and

deputy manager had to cover care visits, this has had detrimental to their management roles and the service was not being managed effectively. Not all of the people and their relatives we spoke with had been made aware of how to make a complaint and had not been given a copy of the services' complaints policy.

Staff received training and supervision and development opportunities. For example, staff were offered to undertake additional training and development courses to increase their understanding of needs of people using the service. However, because of the high turnover of staff recently the staff had mainly only attended the mandatory training, included safeguarding training, meaning that staff had received training to recognise the potential signs of abuse and what action to take to keep people safe.

The service considered peoples' capacity using the Mental Capacity Act 2005 (MCA) as guidance. However, very few of the current staff had received this important training to ensure they have an understanding of the MCA and observed the key principles in their day to day work. Although people told us that staff did check that they were happy for them to undertake care tasks before they proceeded.

The service asked for feedback from the people who used the service by visiting them or over the phone regularly. They were in the process of sending out annual surveys to people and their relatives and the quality assurance policy stated that the survey results would be used to identify areas of the service that needed to be changed to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service had not always been safe.

There were not always enough appropriately recruited staffing levels to meet the needs of people who used the service.

Assessments were not always undertaken of risks to people who used the service and staff.

People were not always supported to receive their medicines safely.

Staff had received training that made them aware of safeguarding procedures and the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The majority of staff had not received the training needed to give them an understanding of the Mental Capacity Act 2005. But people told us that staff protected their rights in relation to making decisions about their care and treatment on a day to day level.

People were not always supported at mealtimes to access food and drink of their choice in their homes in a timely manner.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service told us the care staff were caring and friendly, but did not always understand their needs and sometimes became over familiar and too involved in their care.

People were involved in making decisions about their care and the support they received but it was not always followed.

People's privacy and dignity was not always respected nor was their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments were undertaken and but care plans were not always in place to identify people's health and support needs. Nor were they revised or people's need reassessed when their health deteriorated

There was a system in place to manage complaints and comments. People felt able to make a complaint but were not always confident that complaints would be listened to and acted on.

Staff were not always aware of people's preferences and how best to meet those needs.

Is the service well-led?

Requires Improvement

The service was not well-led

The manager, who was also the provider, did not have systems in place to protect people from harm or to keep people safe. Nor did they ensure that there were sufficient numbers of staff available to attend to their assessed needs in a timely manner.

The manager carried out regular audits to monitor the quality of the service but did not always action to correct poor practice.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 29 and 30 November 2016, and on the 5 December 2016. The first day was unannounced the other days were announced. We carried out this inspection in response to receiving information of concern. The inspection team consisted of one inspector.

Before the inspection we checked the information that we held about the service and the provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with five people of the 29 people who used the service at that time, two of their relatives, the deputy manager and the manager, who is also the provider.

We reviewed a range of records about people's care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, four staff training records, support and employment records, quality assurance audits and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they did not always feel safe using the service.

We saw the service had skilled and experienced staff to ensure people were safe and cared for during visits. We looked at the visit plans and saw that normally there were sufficient numbers of staff employed to ensure visits were covered and to keep people safe, the manager was part of the care team. However, after a one off event, the manager was prevented from driving and supporting people with personal care. This meant that there was not enough staff to cover all the care calls. The manager searched for a care agency and took on an agency worker. Because of the emergency situation the manager was satisfied with the assurances of the agency that the worker was fully trained and had all the clearances they needed to protect people from harm. Neither did the manager carryout her usual practice of taking new staff to introduce them to the people who used the service and to make the staff aware of the person's needs.

We had been contacted by people who believed that the service did not have sufficient staff to care properly for the people they supported. The manager told us that they had a number of staff leaving recently and that they were having difficulties recruiting enough staff. Both the manager and the deputy manager, who were office based for the majority of their time, had needed to cover some of the support visits because of the lack of staff. This had a detrimental effect on their ability to carry out their management tasks.

People told us that the care staff were often late, sometimes an hour late, and they were left not knowing if there care staff were going to come at all. They were not informed if the staff were running late, despite being promised that they would get a phone call if they were running more than 15 minutes late. People were given that promise by the manager and it was also written in their Service User Agreement. One person told us that the staff sometimes did not arrive at all; three people told us that on occasion they had been telephoned by the manager and told that they did not have a staff member to send to them, "They just called and said they didn't have enough staff to get one for me." Often that was on the same day as the planned visit. This meant that the people sometimes had to go without help to get up, to take their medicines or to have a meal. One person told us, "I have sat waiting to go to bed and ended up struggling to help myself and having them [the staff] turn up when I've done it all."

We were also told that staff rushed their tasks while they were with people and leaving as soon as they could so they could get to their next visit. One person told us, "This morning they were supposed to stay and hour, they were late coming and only stayed fifteen minutes!" Staff moaned about their workload during people's visits and told them they that they did not get traveling time added onto their visit plan so they were always going to be late for the next person. One person told us, "… after they have said that, what are you going to say when they look at their watch and ask if I need anything else done before they go?"

The carer roster clearly showed that staff were not given a time allowance to travel between people.

Recruitment procedures were in place but it was the providers practice to start staff working before references were received and before the service had received the result of Disclosure and Barring Service

(DBS) checks. This meant that the service had not always ensured that only staff suitable to work with vulnerable people were employed. For example, one staff member was recorded as starting work on 28 August 2016; at the time of our inspection their DBS check had not been returned. There was only one reference on file that was dated 12 October 2016 and there was a note on their file that they would not have to be shadowed. We asked the manager to explain what the comment meant and were told that because the staff member had experience working in care they did not feel that they needed to shadow other experienced staff before starting to work on their own. Meaning that a new staff member, who had not had their safeguarding checks completed, would be going in to work with people without being introduced to them. People told us that they often had staff they had not met before walk into their home to support them with personal care. One person said, "I have no regular person, I don't know who to expect and sometimes a complete stranger walks in!"

There was not always sufficient staff to care for the people who use the service. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to receive their medicines safely. We saw policies and procedures had been drawn up by the provider to ensure medicines was managed and administered safely. However, we saw that staff had not completed the medicines administration records (MAR) in a way that protected people's safety. All those we saw had gaps where staff had failed to sign them. This indicated that people were not getting their medicines as prescribed. Alternatively, staff supporting those people could not be confident that they had their medicines and mistakes could occur by people being offered their medicines again. Both scenarios would put people at risk and their health in danger. Some of the MAR sheets were badly hand written, with some of the medicines squashed in at the bottom of the page; this practice could also lead to medicine errors occurring.

We also saw that people's medicine care plans did not always correspond with their MAR sheets. Records showed that staff were giving one person their medicines where their care plan indicated that they managed their own medication assisted by their partner. Another area that could cause misunderstanding and lead to medicine errors.

The service had not properly ensured that the medicines were dispensed and recorded properly. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risk assessments were not always in place to give guidance and support for care staff to provide safe care in people's homes.

Some of the people who used the service did not have care plans in place and neither had appropriate risk assessments been carried out. Those people who did have care plans did have risk assessments which identified the level of risks and listed the measures taken to minimise those risks. These covered a range of possible risks such as nutrition, skin integrity, falls and mobility.

People were protected from the risk of abuse because staff were trained to identify and report any concerns they might have. Staff had access to guidance to help them identify abuse and respond in line with the provider's policy and procedures. Records showed that staff had received training in keeping people safe from the risk of abuse.

Requires Improvement

Is the service effective?

Our findings

People felt that staff were normally skilled to meet their needs and spoke positively about the care and support they received from care staff. Comments we received included "They [the staff] seem to be well skilled." Another person said, "I seem to get different girls [staff] every day so they don't always know me… Sometimes they are very new and don't know where to start, I'm not sure they had any training."

Staff received their essential training in topics such as moving and handling and medication. The training plan documented when training had been completed and when it would expire. New staff received mandatory training at the beginning of their employment and all received update training when needed. This meant that the staff had the knowledge and skills required to meet their needs. We were told the service offers qualifications in care to its staff, such as National Vocational Qualifications in social care.

Staff had regular supervisions and the manager planned to set up annual appraisals, the service had been registered a little over a year. These supervision meetings gave staff an opportunity to discuss how they felt they were getting on and any development needs required. Records showed that staff had contact regularly with their manager in the office or via a phone call to receive support and guidance about their work if needed. Staff also received work performance spot checks when working in a person's home. This was to ensure that the quality of care being delivered was in line with best practice and reflected the person's care plan.

There had been a high staff turnover which meant that only a few of the current staff team had Mental Capacity Act (MCA) training, but the manager had planned training for all those staff that needed it. However, people told us that staff respected their choices in the way they wanted to be cared for. One person told us, "They [the staff] ask me what I need and listen to how I want it done." Another person told us, "Sometimes I have to tell them all I need them to do, but they do it OK." If it was apparent that people did not have the capacity to make specific decisions around their care, the staff involved their family or other healthcare professionals to make a decision in their 'best interest' as required by the Mental Capacity Act 2005. A best interest meeting considers both the current and future interests of the person who lacks capacity, and decides which course of action will best meet their needs and to keep them safe.

People were supported at mealtimes to access food and drink of their choice. Much of the food preparation at mealtimes was minimal, with family members preparing the food in advance or people having frozen meals ready to be prepared. So staff were mainly required to make sandwiches or to reheat and ensure meals were accessible to people. However, people told us that some of their visits were so erratic that sometimes they had only just been given breakfast when the staff doing the lunch time visit turn up and get their main meal prepared. Then their evening meal could be may be late. One person told us that, "They [the staff] don't have to do much. I have meals in the freezer and I chose which one I want." Another person said, "I don't know what's going on, the other day I still had my morning cup of tea when they arrived to do lunch!"

The manager told us that they asked staff to encourage people to eat and drink and to make sure drinks and

snacks were left out for people if they needed them. If staff had any concerns about people not eating or drinking enough they are expected to report back to the office or let their family know so that action could be taken to ensure people get enough to eat.

People using the service said that most of their health care appointments and health care needs were co-ordinated by themselves or their relatives. However, staff were available to support people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed. One person told us, "I wasn't feeling well; when they [the staff] arrived they saw I was ill and phoned the doctor for me."

The manager told us that if it was thought that someone was struggling to maintain their health or needed advice and support they would contact their doctor or social worker on the person's behalf.

Requires Improvement

Is the service caring?

Our findings

This service was not always caring. People told us that the care staff were caring and listened to their opinions and choices. One person told us "[The staff] are good people and help me lots." Another said "There're [the staff] great, I can't manage on my own; I just wish they didn't have to rush. I don't see many people."

However, the care staff's caring approach was not reflected in the management decision not to allow traveling time in the staff's visit roster. This meant that staff had to eat into the beginning and end of people's booked care time to try to arrive within the promised window. The manager told us that they asked people to allow fifteen minutes after their visit time before thinking the carer is late, saying that they would telephone people to tell them if their visit was going to be more than fifteen minutes late. People told us that they were not usually called if staff were running late and that sometimes they were left wondering if the staff were going to get there at all, "I waited and waited, I needed to get up and have my tablets, they were so late." People also said that while they understood that emergencies happened and that if someone needed extra support staff had to give it. But felt staff were treated badly and were made to always be on the run. One person told us, "Goodness knows what would happen if I really needed help and they were two hours late!"

People were involved in decisions about their care and support at care plan reviews which were planned to take place annually or when people's care needs changed. However, because of the staff shortages meaning that the management team had to support staff by carrying out care visits, care plans were not being updated as needed. The manager spoke with people regularly by phone and during care visits and asked people if they were happy with the service they received and their care staff, which gave them an opportunity to express their opinions and ideas regarding the service. But people told us that recently their attitude had changed and they had become a bit brusque when they tried to talk about late and missed visits. One person told us, "I know it's difficult at the moment but if I talk to [the manager] she just says 'We don't have the staff."

People told us that staff were respectful of their dignity but that sometimes their privacy was not always maintained. Privacy was respected during personal care, but one person's relative told us that they thought one staff member was too involved and tried to make decisions for their relative and often just popped in to check they were alright. They found it intrusive as they would walk in without knocking or waiting to be asked in. They said, "Our [relative] was very ill and we wanted some quite time with them… but the carer insisted in coming back and just walked in." The manager told us, and staff meeting records evidenced, that protecting people's privacy and dignity were discussed at staff meetings and during staff supervisions. We were reassured that the manager would strongly remind staff to make sure they stayed within professional boundaries and did not to go beyond the person's assessed care package.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Two people we visited in their own homes did not have care plans in place and another two people's care plans had not been updated to reflect their serious deterioration in health, which meant their care needs had changed.

One person told us, "The [the staff] come and have no idea, they stand in front of me and say, 'What do I need to do?' What good it that to me, they should know what to do before they come." Another person said, "They [the staff] keep asking where the care plan is. Then I have to tell them what to do. Some have even started bringing their own notebooks to write down what they've done."

Assessments were undertaken to identify people's support needs and for the majority of people care plans were developed outlining how these needs were to be met. However, we found that new people did not have care plans in place and people whose needs had changed did not have their care plans updated to reflect their needs. One person had moved into the last stage of their life and was being cared for in bed, but the care plan said that they got up and enjoyed a walk outside, that they could feed themselves and walked to the toilet with support from staff. Another person had had a recent stay in hospital and had returned home no longer being able to walk and was being cared for in bed. Their care plan did not reflect these changes.

Overall, the other care records we saw had enough information for the carer to understand what care people needed, but were not holistic or person centred. One sentence or less was often all the information given on how to meet the person's needs.

Some people told us that they were happy with the service they received, one person said while they understood the difficulties the manager had with keeping staff, they were disappointed their care had been affected detrimentally. They told us, "Things were going so well, and then it all changed." Another person told us that the staff were, "… lovely people, they do what they can but are so rushed these days."

Staff completed daily records of the care and support that had been given to people. Some of those we looked at were not detailed and indicated that support people were given was task lead. This meant that neither the staff following or the person's main carer and family were kept fully informed of the support their family member had received.

People told us that they thought that it was important to them that they got the same carer or small group helping them, but said that this did not happen; they were not told who was coming to support them and were not always introduced to new staff before they started working with them. One person said, "I would like to get the same carer, but I don't anymore, they are different every time." The manager told us that they thought it was important that people received support from the same regular staff or small group of staff, which would give continuity of care to people and would mean that they would get to know their cares and did not have to keep telling staff what they wanted and how it should be done. However, the recent high turnover of staff meant that they were struggling to cover the visits and they could no longer give people

that continuity.

The service did not ensure that people had care plans in place that were up to date and held the right information. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not all the people who used the service had been given the information they needed to so that they knew how to make a complaint. Other people who had been given a care folder that contained their care files and the services' information pack, had the details they needed to enable them to make a complaint. The people we spoke with told us that the manager did not always show a caring and supportive attitude and were sometime given short shrift if they made a complaint. One person said, "It was all good, but things have gone wrong, when I complain I just get told, 'We don't have the staff'." Another person told us, "I didn't know who to call, my [relative] had made all the arrangements, [they] phone and told her [the manager] I didn't have a care plan, she said they'd been so busy, we will get it in a couple of days. That was weeks ago." One person's relative told us that they had spoken to the manager and, "She said the right things, promised us the moon but didn't come up with it."

This meant that people did not always have access the services' complaints procedure and could not be confident that their complaints would be dealt with to their satisfaction. This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service well-led?

Our findings

This service is not well-led. People said told us that the management of the service was disorganised, "Hit and miss." One person told us "[The manager] doesn't seem to know what she's doing; she has to do so much care work all her stuff doesn't get done." And another said, "It's been very hard for [the manager] but we're the ones that suffer."

The manager had set up a system of checks and internal quality audits on the service. The audits covered areas such as systems for the management of complaints, medicine records and care records. However, we found that they did not have sufficient systems in place to protect people from harm or to keep people safe. For example, care plans were not put in place or kept up to date and people's medicines were not always managed and recorded properly. Nor did they ensure that there were sufficient numbers of staff available to attend to their assessed needs in a timely manner.

The manager was part of the care team which had a detrimental effect on their management duties and left to the service being poorly managed. This led to people receiving a service that did not meet their needs and left them feeling unsafe and dissatisfied.

The manager said that they tried to create an open and inclusive culture at the service. People told us that they had found the manager open and helpful, but that while under stress with the recent staffing crisis they were sometimes disorganised and was not always receptive towards people. They told us that the manger, who was also the provider, did not always have time to talk to them and could have a curt and unhelpful manner, but was open about the problems they were having and the difficulties they were experiencing.

The manager had set up a system of checks and internal quality audits on the service. The audits covered areas such as systems for the management of complaints, medicine records and care records. However, we found that they did not have sufficient systems in place to protect people from harm or to keep people safe. For example, care plans were not put in place or kept up to date and people's medicines were not always managed and recorded properly. Nor did they ensure that there were sufficient numbers of staff available to attend to their assessed needs in a timely manner.

The manager was part of the care team which had a detrimental effect on their management duties and left to the service being poorly managed. This led to people receiving a service that did not meet their needs and left them feeling unsafe and dissatisfied.

Records showed that feedback from people was sought either face to face or by telephone. The manager had started preparations seek feedback from the people who used the service by sending out a quality assurance survey that could be returned anonymously. They told us that they were committed to take action to make improvements if problems were identified.

Records showed that staff had regular communication with their manager and through one to one supervisions, phone calls and dropping into the office, which the manager encouraged.

The service was not well-led. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not ensure that people had care plans in place that were up to date and held the right information.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not ensured that the medicines were dispensed and recorded properly

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People did not always have access the services' complaints procedure and could not be confident that their complaints would be dealt with to their satisfaction.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well led, there are not enough staff employed to allow the provider to lead the service effectively.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

There was not always sufficient staff to care for the people who use the service.